MALPRACTICE AND PRIVILEGES QUESTIONNAIRE

For use of this form, see AR 40-68; the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title 5, United States Code (USC), Sections 3109 and 3301. *(Title 5, USC, Section 552a)*

Principal Purpose: To obtain U.S. Civil Service appointment.

Routine Uses: Basis for determination of qualifications and background information for the eligibility for appointment. Basis for credentialing health care providers.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information will result in nonacceptability of the application.

The policy of the Army is to screen, verify and validate statements, assertions and documents of all applicants for health care provider positions. As part of this process, please complete the following statements *(as applicable to your profession).*

1. NAME OF INDIVIDUAL	2. SOCIAL SECURITY NO. *(SSN)*

HAVE *(YES)*	HAVE NOT *(NO)*	
		3. Had medical liability claims, settlements, judicial or administrative adjudications, or any other resolved or open charges of inappropriate, unethical, unprofessional or substandard professional practice. *(If affirmative explain each incident in item 13 below.)*
		4. I am licensed/registered/certified by the authority named in item 13 below. *(List all current and past licensures held (include issue and expiration date). Explain the circumstances surrounding the suspension or revocation of licensure previously held.)*
		5. Had my professional license denied, withdrawn, or restricted by a state or local licensing board or other authority. *(If affirmative, give organization name, address, and dates involved in item 13 below.)*
		6. Had professional privileges denied, withdrawn, or restricted by a health care facility. *(If affirmative, give the organization name, address, and dates involved in item 13 below.)*
		7. Resigned or otherwise disassociated myself from employment or practice after being notified of intent to start action against me for failure to properly accomplish my professional responsibilities. *(If affirmative, give the organization name, address and dates involved in item 13 below.)*
		8. Are you now or have you ever been required to appear before any medical or state regulating authority, regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted practitioner? *(If affirmative, give brief explanation in item 13 below.)*
		9. Had a history of drug or alcohol abuse or misuse. *(If affirmative, explain in item 13 below.)*
		10. Do you have any disease or impairment which would make your employment a hazard to yourself or others? *(If affirmative, please list in item 13 below. In addition, please provide a brief description of your health status.)*
		11. I hereby authorize the U.S. Army to contact my current and previous malpractice carrier/licensing organizations for the purpose of verifying the above information.

		11a. CARRIERS *(Name and Address current and previous)*	11c. LICENSING ORGANIZATION *(Name and Address current and previous)*
		11b. POLICY NO	
		12. I hereby authorize the U.S. Army to contact the following institution(s) for the purpose of verifying the status of my current professional privileges:	
		12a. ORGANIZATION *(Name and Address)*	12b. DATE(S)

13. CLARIFICATIONS, EXPLANATIONS, ETC., REGARDING ITEMS 3-10 ABOVE *(Identify by appropriate item number.) (Continue on reverse side if necessary.)*

14a. TYPED/PRINTED NAME OF APPLICANT	14b. SIGNATURE OF APPLICANT	14c. DATE